

TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

ATTACHMENT 4.19B

State of Colorado

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER  
TYPES OF CARE:**

1. Outpatient hospital services are reimbursed on an interim basis of actual billed charges times 72% of the Medicare cost to charge ratio. A periodic cost audit is performed and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less twenty eight percent (28%) or billed charges less twenty eight percent (28%).
2. Reimbursement for outpatient clinical diagnostic laboratory tests may not exceed sixty percent (60%) of the Medicare prevailing charge fee schedule.
3. Outpatient anatomical laboratory tests are reimbursed on an interim basis based upon the Medicaid fee schedule. A periodic cost audit is performed and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost or the Medicaid fee schedule.
4. Out-of-state outpatient hospital services are reimbursed at seventy percent (70%) of billed charges for covered services.
5. An exception to the above is reimbursement for outpatient dialysis treatment. Routine dialysis services will be paid at the Medicare composite rate of reimbursement. Routine services are all services provided in conjunction with the dialysis treatment.

Effective July 1, 1991, non-routine ancillary services will be reimbursed separately. Non-routine services include laboratory, drugs and blood or blood products. The state has adopted the Medicare frequency limitation for non-routine services. An exception is the reimbursement for the drug epotein. This drug is billed in accordance to State Plan 4.19B 2C.

6. Effective November 1, 1991, when a court-ordered inpatient admission DOES NOT meet the PRO Acute Care Criteria, such stay will be denied by the PRO. If the court-ordered psychiatric inpatient case is denied by the PRO, then the provider may submit an outpatient claim to recover the facility outpatient costs. The claim must be accompanied by a PRO certification letter which reflects the denied court-ordered inpatient stay.

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TN No. 92-008 Approval Date 11/05/97 Effective Date 7-1-97

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - FEDERALLY QUALIFIED  
HEALTH CENTER (FQHC) SERVICES

Effective September 1, 1990, the Colorado Medical Assistance Program shall reimburse Federally Qualified Health Centers (FQHCs) 100 percent of costs which are reasonable and related to the cost of providing FQHC and other ambulatory care services.

All FQHCs including hospital-affiliated and non-hospital-affiliated health centers, are required to file annual cost reports. Audited cost data from these reports will be compiled for all participating FQHCs and will be used to set yearly FQHC reimbursement rates. The State will determine and assure that the payments are based upon, and cover, the reasonable costs of providing services to Medicaid beneficiaries.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - PHYSICIAN SERVICES

Effective November 1, 1987, the Medicaid Program will reimburse for physician services in accordance with the lower of the following:

- A. The rate determined by completing the calculation set out below using the HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS). This calculation consists of multiplying a unit value by a conversion factor.

1. Unit Values

The associated unit values shall be determined using, when available, information from three data sources:

- a. Input from a consultant who reviewed such specialty area;
- b. 90th percentile of charge data from basic Blue Shield;
- c. The current unit value for each code (1971 RVS).

When these data are obtained, the unit value is determined as follows:

- a. When information from all three of the sources listed above is available, the middle unit value is used.
- b. When information from only two sources is available, the average unit value is used.
- c. When only one source of information is available, the unit value indicated by this information is used.
- d. Bilateral Surgery - The second surgery is paid at 80% of its normal payment rate.  
Micro Surgery - Unit value is increased by 25%, except when micro surgery was the original basis for such unit weight selection.

Once the unit value is determined, it is multiplied by a conversion factor.

2. Conversion Factors

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e. medicine, surgery, anesthesia, pathology, and radiology) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for each procedure. Details about conversion factors historically applied on specific dates are available at the Medical Assistance Program office. TRANSMITTAL NO. 88-2

- B. Provider's Actual Charge.

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Effective Date 11/1/88

Supersedes Transmittal \_\_\_\_\_

Micro Surgery - Unit value is increased by 25%, except when micro surgery was the original basis for such unit weight selection.

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e., medicine, medical consultation, surgery, assisting to surgery, anesthesia, laboratory and x-ray) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for such procedures.

The conversion factors shall be selected utilizing the following criteria:

1. Analysis by geographic area and specialty using data establishing the percentage of charges being paid, current physician participation in each specialty, and the medical needs of recipients in order to ensure recipient freedom of choice and adequate physician participation in the program;
2. The percentage of billed charges for each type of service not to exceed a reimbursement rate of 80 percent of such charges; and
3. Available appropriations.

HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS) conversion factors and associated unit values may be modified from time to time to meet Medicaid Program requirements to accommodate changes in medical practice, changes in medical terminology or the addition or deletion of procedure codes by medical specialties.

B. Provider's actual charge.

Exceptions to the above reimbursement method are payments for outpatient clinical diagnostic laboratory tests performed by a physician or independent laboratory. These test will be reimbursed at the lower of the provider's actual charge or a rate of reimbursement equal to the rate paid by Medicare. Additional exceptions to the above reimbursement method are payments for services provided by audiologists, occupational, speech, and physical therapists, dentists, and opticians or providers of eyewear.

Occupational, and physical therapists are not reimbursed directly. Their services are allowable costs used in the determination for rates for nursing homes, hospitals, and home health agencies.

Audiologists or speech pathologists shall not receive direct reimbursement if they are acting within the scope of their graduate education training program, or as contract agents or employees of a nursing home, hospital, FQHC, clinic, home health agency, a school or a physician.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-OTHER TYPES OF CARE

EPSDT

- A. For medically necessary services not otherwise provided under the State Plan but available to EPSDT participants:

Reimbursement rates will be calculated by:

1. review of the provider's submitted charge;
2. review of other like provider's usual and customary charge for like services;
3. review of other third party payor's reimbursement rates.

The Medicaid reimbursement rate will be the lower of the submitted charge or the rate determined from research to be equitable in relation to other Medicaid reimbursement rates.

- B. For dentally necessary services not otherwise provided under the State Plan but available to eligible EPSDT participants:

Reimbursement rates are based on the established fee schedule unless a lower amount is billed.

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Supersedes  
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4 (b), EPSDT Screening and Other Services

## Reimbursement Methodology for School-Based Health and Related Services

## 1. Overall Methods and Standards

Reimbursement rates shall be on a fee for service basis. The Department will pay average statewide rates that are developed according to Department formula. Rates are based on the costs of providing school health and related services by participating providers. With the exception of the school health encounter (partial ESPDT screen), costs for school-based health services shall be calculated on an encounter basis, aggregated in 15-minute increments. Time studies and/ or audits will be performed periodically to help ensure encounter rates do not exceed costs incurred.

## 2. Standards and Methods Specific to Special Transportation

Special transportation costs are based on an average per trip rate established for each district from data furnished in uniform district-specific transportation cost reports required by the Colorado Department of Education (form CDE-40). Reimbursement amounts may be adjusted periodically based on results of subsequent cost reports.

## 3. Standards and Methods Specific to the Administration of Immunizations

Reimbursement for the administration of immunizations does not include the cost of vaccine when vaccine is available from another federal source. Reimbursement for the administration of immunization shall be made on the basis of cost.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - CERTIFIED FAMILY AND PEDIATRIC NURSE PRACTITIONER, CERTIFIED REGISTERED NURSE ANESTHETIST, AUDIOLOGIST AND SPEECH PATHOLOGIST SERVICES.

Effective October 1, 1990, Certified Family and Pediatric Nurse Practitioner and Certified Registered Nurse Anesthetist services, and effective July 1, 1993, Audiologist and Speech Pathologist services, shall be reimbursed in accordance with the lower of the following:

- A. The rate determined by completing the calculation set out below using the HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS). This calculation consists of multiplying a unit value by a conversion factor.

1. Unit Values

The associated unit values shall be determined using, when available, information from three data sources:

- a. Input from a consultant who reviewed such specialty area;
- b. 90th percentile of charge data from basic Blue Shield;
- c. The current unit value for each code (1971 RVS).

When these data are obtained the unit value is determined as follows:

- a. When information from all three of the sources listed above is available, the middle unit value is used.
- b. When information from only two sources is available, the average unit value is used.
- c. When only one source of information is available, the unit value indicated by this information is used.
- d. Bilateral Surgery - The second surgery is paid at 80% of its normal payment rate.

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Supersedes  
TN No. 90-15

Micro Surgery - Unit value is increased by 25%, except when micro surgery was the original basis for such unit weight selection.

Once the unit value is determined, it is multiplied by a conversion factor.

## 2. Conversion Factors

The conversion factor represents an appropriate numerical value as selected for each type of service (i.e. medicine, surgery, anesthesia, pathology, and radiology) which will, when multiplied by the appropriate unit value assigned to each procedure, determine a unique dollar value for each procedure. Details about conversion factors historically applied on specific dates are available at the Medical Assistance Program office.

### B. Provider's Actual Charge.

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**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES –  
INDIAN HEALTH SERVICES**

Effective January 1, 2000, Indian Health Services (HIS) and Tribal 638 facilities are paid in accordance with the most current Federal Register Notice, published by the Indian Health Services and approved by Health Care Financing Administration (HCFA)

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